IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8798

June 12, 2006

James Roberts, Administrator
Idaho State Veterans Home - Boise
P.O. Box 7765
Boise, ID 83707

Provider #: 13A035

Dear Mr. Roberts:

On **June 2, 2006**, a Recertification survey was conducted at Idaho State Veterans Home - Boise by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be an isolated deficiency that constitute actual harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 26, 2006**. Failure to submit an acceptable PoC by **June 26, 2006**, may result in the imposition of civil monetary penalties by **July 17, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **July 7, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 7, 2006**. A change in the seriousness of the deficiencies on **July 7, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 7, 2006** includes the following:

Denial of payment for new admissions effective **September 2, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 2, 2006**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene

Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 2, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **June 26, 2006**. If your request for informal dispute resolution is received after **June 26, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13A035	A. BUILDING _____ B. WING _____	06/02/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISVH - BOISE	PO BOX 7765 BOISE, ID 83707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Winnie Young, RN, Team Coordinator Kim Heuman, RN Lea Stoltz, QMRP Lory Dayley, RD Karen McDannel, RN Diane Miller, LCSW Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	RECEIVED JUN 26 2006 FACILITY STANDARDS	
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to provide an accessible call light to 1 of 21 sampled residents	F 246	**F 246 – SS=D – Accommodation of Needs** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The resident identified as being affected by the deficient practice was given a call light with a longer cord to allow for him to have access to the call light while in bed and while sitting in his recliner. At times, this resident is capable of independent mobility in his room and of moving the call light from one location to the other. Resident has been encouraged to relocate the call light to his recliner (when appropriate) instead of wrapping it around the door handle. Staff has been inserviced to monitor call light location and place call light by resident in the event resident has forgotten.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James E. Roberts NHA	ADMINISTRATOR	6/26/2006

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 currently residing in the facility (#18). Findings include: Resident #18 was admitted to the facility on 10/02/02, with the diagnoses of dementia, diabetes mellitus, obesity and osteoarthroses. During an observation on 06/01/06 at 8:30 am and 9:00 am resident #18 was sitting in his wheelchair by the side of his bed. The call light cord was strung through the handle of the residents wardrobe which was located on the opposite side of his bed. The call light was not accessible to the resident. At 9:30 am and 10:00 am the resident was in his room sleeping in his recliner at the head of his bed and the call light cord was strung through the handle of the residents wardrobe which was located on the opposite side of his bed. The call light was not accessible to the resident. The nurses notes on 05/22/06 at 5:55 pm document that on 05/22/06, resident #18 fell while self transferring from his wheelchair to a recliner. The Fall Risk Assessment scored resident #18 at a score of 17. A total score of 10 or above represents high risk for falls. On 6/1/06 at 10:00 am, a staff interview was conducted with the Unit Manager regarding resident #18's call light not being accessible. The surveyor inquired of the Unit Manager if resident #18's call light should be within his reach. She confirmed that yes it should especially with his recent falls and high fall risk. She went on to state that resident #18 quite frequently will move his call light from where the staff place it if he doesn't like where it is at. On 6/01/06 at 10:30 am the	F 246	2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents are required to have call lights immediately accessible, therefore all residents have the potential to be affected by the deficient practice and corrective action was taken. In order to ensure that all the residents have access to call lights – while in bed, recliners, etc. an evaluation of all residents' call light status was completed. When identified as appropriate, longer call lights or dual-type call lights were obtained to allow ready access to call lights regardless of the resident's location in the room. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Central Supply was notified of the need to additional/different call lights and these were purchased and implemented. Residents identified as needing alternative call lights were care planned accordingly. Staff was inserviced related to the need to locate a call light near the resident – while in the room – regardless of the location of the resident. Upon admission and at least quarterly call light needs will be access for each resident and adjustments implemented and care planned as appropriate. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. The current QA monitor for "Resident in Room" was revised to reflect the potential for the need of "special" call lights for those residents who have recliners, etc. in their room – the need for longer or two call lights.	

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F 246	Continued From page 2 Unit Manager reported that the CNA had placed the call light within resident #18's reach and that resident #18 is who strung it through the wardrobe in his room. She stated that the facility will evaluate possible solutions to this issue with the call light not being accessible to resident #18.	F 246	5. Include dates when corrective action will be completed. Corrective action will be completed by July 7, 2006.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined that comprehensive care plans were not periodically reviewed and revised by a team of qualified persons after each assessment. The care plan for resident #3	F 280	**F 280 - SS=D – Comprehensive Care Plans** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. One resident was identified as being affected by the deficient practice. In this instance the resident was care planned for the use of 2 ½ side rails. These side rails were not identified on the side rail assessment, quarterly Medicare assessment or a physician's order. The resident's care plan and Side Rail Assessment were completed and a physician's order was written to reflect the resident's current side rail usage and to ensure consistency among the documents. This same resident's care plan also indicated that his sleep be monitored. This was not occurring because the sleep medication that necessitated this monitoring had subsequently been discontinued and the care plan was revised accordingly.	

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F 280	Continued From page 3 instructed staff to use 1/2 siderails even though the side rail assessment, quarterly medicare assessment MDS and physician's orders all instructed to not use siderails. Also, the care plan for resident #3 instructed the staff to monitor him for number of hours of sleep. This was true for 1 of 21 sampled residents (#3). Findings include: 1. Resident #3 was admitted to the facility on 10/16/04, with the diagnoses of malignant nasopharynx, hypertension, acute pancreatitis and hepatitis C. The quarterly assessment MDS, signed 04/05/06, under devices and restraints documented, "not used under other type of siderails (e.g., half rail, one side)." The resident also triggered on the MDS for, "fall in the past 30 days" and "fall in the past 31-180 days." The physician's order dated 04/17/06 documented, "Siderails: Resident is care planned for no siderails." Resident #3 had a physician order for, "Morphine Elixer 120 mg q [every] 3 hours via peg." The Nursing 2006 Drug Handbook documented the following potential adverse reactions to individuals administered morphine elixor, "sedation, clouded sensorium, dizziness, abnormal gait, delirium and abnormal thinking." The care plan, dated 04/11/06, identified a problem as, "Mobility, altered/Risk for falls." Approaches included, "1/2 siderails up X [times] 2 for bed mobility." On 05/31/06 at 6:40 am resident #3 was	F 280	2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents have the potential for side rail usage when assessed and determined to be warranted or when requested by the resident. Therefore all residents have the potential to be affected by this deficient practice and corrective action was taken. An audit of all current residents' use of side rails was evaluated and updated using the facility's Side Rail Assessment form. A corresponding physician's order was written, as needed, and the care plan revised accordingly. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Unit RN Managers will review all physician orders and revise care plans accordingly (thus the sleep monitor would have been removed from the care plan in a timely manner). MDS Coordinator will consult with the Unit RN Manager during the MDS observation period to ensure assessments reflect care plan interventions. The Unit RN Manager will include the certified nursing assistant's in the review and revision of care plans (ongoing and in conjunction with the MDS schedule) – to assist in ensuring that the interventions indicated in the care plan are reflective of the resident's current situation (thus the side rail inconsistency would have been noted and corrected).	

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F 280	Continued From page 4 observed lying in his bed with both 1/2 siderails raised on his bed. The nurses notes on 04/04/06 at 12:00 am and 05/16/06 at [no time specified just am] document, " 1/2 siderails up X 2." The nurses notes on 3/17/06 at 8:00 pm document that the resident had fallen when he tripped over a rug in the hallway. A staff interview was conducted on 05/31/06 at 6:45 am with the Unit Manager regarding resident #3's siderails. The surveyor reviewed the fact that the quarterly assessment MDS, signed 04/05/06, the physician order's dated 04/17/06 and the side rail assessment dated 03/29/06 all document that the resident is not care planned nor assessed for siderails. However, the care plan, dated 04/11/06 identified an approach as "1/2 siderails up X 2 for bed mobility." The unit manager stated that the resident requests prn [as needed] for the side rails to be raised. She went on to state that the resident at times will raise the siderails himself. She stated that the care plan will need to be updated to reflect the siderail usage. The facility failed to review and revise the resident care plan to reflect the assessment and physician's orders regarding the use of siderails. 2. Resident #3 was admitted to the facility on 10/16/04, with the diagnoses of to malignant nasopharynx, hypertension, acute pancreatitis and hepatitis C. The care plan, dated 4/11/06, identified a problem: "Sleep Cycle Disturbance." Approaches included, "Monitor number of hours of sleep per	F 280	F 280 Continued from page 4 The Interdisciplinary Team (those involved in the RAI process) will individually review their care plan interventions and also those of the other disciplines prior to the quarterly care plan conference. If a duplication or contradiction is identified then this/these will be resolved by the team during conference. The Interdisciplinary Team, including the MDS Coordinator and the Unit RN Managers were inserviced related to the above measures/systemic changes. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. The QA monitor for Side Rail Assessments was revised to reflect the need to ensure that the care plan and physician's order are consistent and current with each resident's side rail usage. The QA monitor for Care Plans was revised to include review of care plans against physician orders and was also revised to include monitoring for duplication and inconsistently among identified problems, goals and interventions. 5. Include dates when corrective action will be completed. Corrective action will be completed by July 7, 2006.	

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F 280	Continued From page 5 night." On 5/31/06 at 7:00 am, a staff interview was conducted with the Unit Manager regarding resident #3's sleep monitoring. The surveyor reviewed the fact that the care plan instructed staff to monitor the residents number of hours of sleep. The Unit Manager stated that resident #3 had previously been administered sleep medications which have since been discontinued. She stated that the sleep monitoring instructions should have been removed from his care plan. The facility failed to update the care plan when the residents sleep medication was discontinued.	F 280		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined the facility failed to ensure that each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. This affected 1 of 21 sampled residents (#3) reviewed for care plans. The facility failed to follow the care plan in relation	F 309	**F 309 – SS=D – Quality of Care** 1. <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</u> One resident was determined to be affected by the deficient practice. The reference in the care plan to "observe for relief 30 minutes after medication administration" is a standard statement for the majority of residents using PRN pain medications and did not apply to this resident because his PRN pain medication had been discontinued. This care plan statement was also inaccurate because this resident had previously been determined to not requiring assessment of the effectiveness of pain medications because of his psychosocial status and history of narcotic abuse. The resident is also able to communicate his needs/status to the staff if he were experiencing pain. As a result, the reference to "observe for relief 30 minutes after medication administration" was removed from the care plan to reflect the resident's current needs/interventions.	

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F 309	Continued From page 6 to pain treatment for resident #3. The findings include: Resident #3 was admitted to the facility on 10/16/04, with the diagnoses of malignant nasopharynx, hypertension, acute pancreatitis and hepatitis C. The quarterly review assessment MDS, signed 3/29/06, under pain symptoms, indicated the resident had no pain. The Physician's Recapitulation Orders dated 05/01/06 stated: "Morphine Elixer 120 MG [milligram] via peg Q [every] 3 hours. Assess patient prior to each dose. Document '+' for S/S [signs and symptoms] pain, or '-' for no S/S pain..." The care plan, dated 4/11/06, identified a problem: "Comfort Level." Approaches included, "Administer analgesic (routine) per MD order. Assess resident for pain prior to each dose and document on MAR [medication administration record]. Routine analgesic to be administered regardless of s/s of pain if awake. Observe for relief 30 minutes after medication administration." The May MAR states, "Assess patient prior to each dose. Document '+' for S/S pain, or '-' for no S/S pain." Review of the May 2006 MAR for Resident #3 revealed the facility consistently documented the residents S/S of pain prior to the administering of the pain medication. However, there was no documentation of the observations of the relief of the pain 30 minutes after the medication had been administered.	F 309	F 309 Continued from page 6 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. The majority of the facility's residents have orders for pain medications – regularly scheduled and/or PRN - and therefore have the potential to be affected by the deficient practice. Corrective action was taken. All residents' MARs/ physician orders were audited to ensure that a pain monitor was present (in accordance with the facility's procedure) and changes made as deficiencies identified. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The facility's Pain Assessment/Management procedure was revised to better reflect the appropriate interventions for the use of pain medications. A monitor for assessment of a resident's pain prior to and after the administration of a pain medication was added to the FRONT of the mar for easy access and identification of inadequate pain relief. The library (Monette software) was updated related to appropriate care plan interventions for the use of a pain medication to better reflect monitoring related to the use of PRN pain medications and regularly scheduled pain medications. All Care Plans were reviewed to ensure pain medication / pain management interventions were reflective of the needs of the resident. The RN Unit Managers will review physician's orders against care plan interventions to ensure consistency and accuracy.	

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F 309	Continued From page 7 On 5/31/06 at 7:00 am, a staff interview was conducted with the Unit Manager regarding resident #3's pain medication. The surveyor reviewed the fact that the care plan instructed staff to document observations for relief of pain 30 minutes after the pain medication was administered. The Unit Manager stated that the facility is tracking the '+' and '-' prior to administering the pain medication as directed by the Physician Orders, however, the observations 30 minutes after pain medication administration was not being tracked by the facility. The Unit Manager acknowledged that this information would be very helpful to provide the treating physician regarding the effectiveness of the medications prescribed. The facility did not adequately assess the resident to communicate with the physician to determine if pain could be controlled by an adjustment to the administration of medications as ordered or exploring use of other medications for pain.	F 309	All licensed nursing staff was inserviced related to the need to ensure care plan interventions accurately reflect current pain medication/management interventions and are consistent with the resident's needs and facility procedure related to Pain Assessment/Management and Alert Charting. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. The QA Monitor for Medication Administration was updated/revised to include assessing for appropriate care plan interventions related to the use of PRN and regularly scheduled pain medications and to audit resident's MAR to ensure appropriate monitor is in place to evaluate effectiveness of pain medication. The QA Monitor for Care Plans also requires that the care plan be evaluated for accuracy and completeness related to the resident's current status. 5. Include dates when corrective action will be completed. Corrective action will be completed by July 7, 2006.	
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	**F 314 – SS=G – Pressure Sores** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. One resident was identified as being affected by the deficient practice. This resident currently does not have a pressure sore (healed) and interventions were implemented that have been successful in relieving pressure with no further re-occurrences of impaired skin integrity. Pressure-relieving devices were also added to each surface known to have the potential to negatively impact skin integrity (gel cushion added to recliner).	

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F 314	Continued From page 8 Based on observation, staff interview and record review it was determined the facility did not ensure residents who were high risk for pressure ulcers and had a history of Stage II pressure ulcers received the proper treatment and services to prevent the recurrence of the Stage II pressure ulcers. This was true for 1 of 6 (#4) residents reviewed for pressure ulcers. The facility did not ensure effective prevention and treatment was based upon consistently providing routine and individualized interventions. Resident #4 had a history of cerebral vascular accident with left hemiparesis and a history of a recently healed Stage II pressure ulcer to the coccyx. The LN admission skin assessment was not done until the next day(11/23/06) after admission to the facility on 11/22/06. Although the resident was at high risk for development of pressure ulcers, the facility did not implement a Select Aire Max Alternant pressure relief mattress until 1/19/06. A total of 19 days after the Stage II pressure ulcer re-developed. This resulted in harm when resident #4's healed Stage II pressure ulcer re-developed and progressed to a Stage III pressure ulcer causing pain, drainage, odor and required antibiotic treatment. Findings include: Resident #4 was admitted to the facility on 11/22/06 with diagnoses that included cerebrovascular disease, diabetes type II, late effect hemiplegia, cerebral vascular accident [CVA], depressive disorder and anxiety. The initial MDS assessment dated 12/05/06, indicated the resident was independent for daily decision making, had no mood or behaviors, needed limited assistance of one person for transfer, bed mobility and dressing. The resident needed extensive assistance of one person for toileting,	F 314	F 314 Continued from page 8 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents have the potential for acquiring pressure sore(s), particularly those identified as being at high risk for skin breakdown. Therefore, corrective action was taken. The Skin/Wound nurse was directed, with consultation with the Unit RN Managers, and review of the residents' medical records, to determine if there was any history of a prior pressure ulcer (pre-admit) and put into place appropriate pressure relieving devices (if none existed). The Skin/Wound Nurse also ensured that all residents with current or healed pressure ulcers have available and utilize a pressure-relieving cushion/device for all surfaces that have the potential to put pressure on the skin area of concern. 3. What measures will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur. The factors considered for determine a resident's risk for developing skin breakdown was revised to include additional ones not considered on the Braden Scale. These items are prior and/or current history of pressure sores, the resident's cognitive status, the resident's compliance with cares, and the resident's peripheral blood flow. The Braden Score + these additional factors will be used to determine risk and assist in determining the most appropriate care plan interventions.	

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F 314	Continued From page 9 hygiene and bathing, and did not have pressure ulcers. The resident was continent of bowel and occasionally incontinent of bladder. The MDS assessment also indicated the resident's skin was desensitized to pain or pressure. A Nursing Progress Note dated 11/22/06 documented, "Resident admitted to [facility] at 1400 [2:00 pm]... from [hospital] where he was receiving therapy following dx [diagnosis] of a CVA with [left] sided weakness on 9/21/05...resident agreed to pressure alarms in w/c and in bed to alert staff of unassisted transfer attempts and he agreed to use his call light to call for assist with ADL's and mobility...denies any discomfort with sitting for long periods. Will monitor. He has a pressure relieving cushion in the w/c provided for him by therapy dept. [department] at the [hospital]. He also has a pressure relieving overlay on his bed. He has a history of coccyx ulcer while hospitalized at the [Hospital], which is documented as healed. LPN to do a skin check this evening." An "Admit Assessment/Nursing" form, dated 11/23/06, contained a posterior diagram of a human with a line drawn to the sacral/coccyx area and a handwritten entry indicating a 1 x 2 cm [centimeter] scar. There was no written assessment on the form describing the sacral/coccyx area or the healed Stage II pressure ulcer area. A RAP narrative dated 11/22/06 for pressure ulcers documented, "Resident triggered this rap d/t [due to] his history of a resolved coccyx ulcer that he was reported to have while at the [hospital]...he is also at risk for skin breakdown d/t	F 314	F 314 Continued from page 9 The Braden Scale procedure was revised to reflect these additional factors. In addition, the guidelines for focus charting (admit and quarterly completion of Braden Scale assessment form) were updated to include these additional factors. If a resident has a history of a pressure sore then they shall be considered "severe risk" regardless of their Braden Score and care plan interventions will be initiated accordingly. If any resident has a history of a pressure sore then interventions will be initiated immediately to provide "severe risk" pressure relief for all surfaces that have the potential to cause pressure on the previously healed pressure sore e.g. pressure relief cushion in wheelchair, recliner, sitting chair, etc. Orders have been placed to obtain mattresses "uniquely designed for pressure reduction for prevention through Single Site Stage III pressure ulcers" to better accommodate those residents who have a history of a Stage I or Stage II pressure ulcer (per above resident). The temporary Care Plan for skin/wound issues was revised to reflect the consideration of other factors, in addition to the Braden Scale score, in determining appropriate interventions.	

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F 314	Continued From page 10 his decreased mobility, diabetes. Resident is able to reposition self in bed with little assistance from staff, he has a pressure reducing overlay on his mattress and a pressure reducing cushion in his w/c [wheelchair]...He also receives a skin check from the licensed nurse weekly per the TAR [treatment administration record]. Will proceed with the care plan." A Care Plan - "Temporary Skin and/or Wound" form dated 11/22/06, documented the following: a) "...2. Utilize a pressure relieving device. Describe: overlay on bed, cushion in w/c [with] gel pads..." b) "...4. Reposition resident every 2 hours while up in w/c, recliner or other. Assist as needed." c) "...5. Administer peri-care after each episode of incontinence, apply moisture barrier cream..." A Care Plan - "Temporary Skin and/or Wound" form dated 1/02/06, documented the following circled approaches: Interpretive Instructions "(Circle applicable interventions)" a) "1. Relieve or reduce factors contributing to wound formation. Describe: Tx [treat] wound per no [new order]." b) 2. Had a hand written instruction for "gel cushion on w/c, overlay on bed". The #2 was not circled and the hand instructions were not dated. b) "...4. Reposition resident every 2 hours while up in w/c, recliner or other. and to lay on side..." c) "...18. Dress wound(s) as ordered." d) "19. Notify nurse of any skin problems identified." e) "20. Notify skin/wound nurse as needed." f) "21. Administer pain medication as needed." g) "22. ABX [antibiotic] per M.D. order."	F 314	F 314 Continued from page 10 The Skin Assessment Program procedure was revised to reflect the requirement for the admitting nurse to assess the resident's skin integrity within six (6) hours of admission. The procedure was also revised to reflect the need to promptly notify the Skin/Wound Nurse and/or Unit RN Manager upon discovery of any skin problems/issues. The procedure was also revised to direct the nurse conducting the admission skin assessment to completely and accurately describe the skin integrity of the site of any current or previously healed ulcers. All licensed nursing staff was inserviced related to the above procedures and processes. All nursing staff was inserviced related to the need to adhere to all care plan interventions. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. The QA Monitor for Skin/Wound was revised to reflect the prompt assessment of skin integrity on admission, the implementation of adequate pressure relieving devices for all surfaces for those residents with a history of pressure sores, and for the determination of a resident to be at severe risk with a history of pressure sores, and for the incorporation of other factors in addition to those identified on the Braden Scale when determining a resident's risk factor for the potential for skin breakdown. 5. Include dates when corrective action will be completed. Corrective action will be completed by July 7, 2006.	

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F 314	Continued From page 11 A revision to the 1/02/06 temporary skin and/or wound care plan had a line drawn through "over lay on bed" and had a handwritten entry "air mattress to bed 1/19/06." Resident's #4's "Resident Plan of Care" dated 5/25/06 documented the following: a) Problem: "Actual alteration in skin-integrity related to dry skin, decreased mobility, occ [occasional] incontinence, multiple metallic foreign bodies noted overlying sacrum & coccyx per x-ray. Likely shrapnel [sic]." b) Approaches: "Special protective devices used: air mattress and a pressure reducing cushion with gel packs inserted in cushion on his w/c. Air mattress on bed purchased by [hospital] for resident to use indefinitely...Keep skin clean, dry, and free of pressure. Assist [name] to reposition q [every] 2 hours. Encourage/assist to lay down after meals...LN to evaluate skin weekly per facility policy...Treatment to coccyx per MD order, to continue as preventative measure - Skin wound nurse to follow weekly and prn. Also seen by [hospital] wound clinic prn." Medical record documentation included the following: a) Nurses notes, 1/02/06 at 10:00 pm, "Resident reported pain to his buttocks. On observation noted 1 x 1 cm circular white moist open area to scar tissue to upper coccyx. Cleaned area [with] ns [normal saline] covered [with] coverderm reminded Resident, while in bed to stay off back as much as possible. Placed on 72 [hour] monitor. Wound nurse notified." b) Nurses notes dated 1/03/06 at 9:40 pm, "Resident has area on coccyx next to skin flap	F 314		

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F 314	Continued From page 12 from scar where skin flap has abraided [sic] the skin over coccyx. Dsg [dressing] order obtained. Area painful [with] palpation. Coraderm applied [and] tucked between the flaps of skin...He allowed staff to position himself [sic] on his side. Will continue to monitor." c) Pressure Ulcer Record dated 01/05/06, "Site A [sacral/coccyx area] - Date first observed 1/05/06 - Stage III - Size .3 x .3 cm - Granulation [none] - Drainage moderate - Odor yes." d) Pressure Ulcer Record dated 1/12/06, "Site A - Stage III - .8 x .6 cm - drainage scant - odor [none] - color cream - response to treatment [increase] size." e) Pressure Ulcer Record dated 1/19/06, "Site A - Stage III - 1.0 x 1.2 cm - depth .2 cm - drainage scant - odor slight - color cream - response to treatment [increase] size." f) Physician's Progress notes dated 2/16/06, "...I have discussed his sacral area skin issues with skin and wound. We are trying to arrange an earlier surgical appointment because there is a surgical opinion that this may require surgical revision. In the mean time, we are aggressively working at healing." g) Physician's progress notes dated 3/9/06, "...surgical revision of this would likely make things worse instead of better. He will be seeing the wound specialist, [physician's name], next week ...The ulcer looks very clean. It is in an area of skin which is stretched thinly over sacral bones ..." h) Consultation Request dated 3/7/06, "referred by Dr. [name] for wound consultation [Physician's name]. i) 3/16/06 at 1030 am, "Imp[ression] (1) sacral wound - progressing well. Rec[ommendation] (1) cont[inue] current wound care (2) xray sacrum (3)	F 314		

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F 314	Continued From page 13 Labs ..." Signed by consulting physician. The pressure ulcer was reviewed weekly by the wound nurse with similar findings documented. The ulcer gradually decreased in size until 5/4/06, when it was documented as healed. On 5/30/06 at 8:30 am, resident #4 was observed asleep in a recliner located in the day room which is in view of nursing station. Again at 10:00 am, the resident was observed asleep in the same recliner. He was observed at 11:15 am, he was asleep in the recliner. A LN told the surveyor that he had stayed in the recliner this morning because he wasn't feeling good. The LN explained he had complained of flank pain yesterday and had blood in his urine. At this time the LN was heard by the surveyor telling another staff member that the resident would not be going down for lunch because he needed to be observed by nursing. On 5/30/06 at 1:15 pm, the resident was observed in the recliner. His daughter was seated next to him. During an interview with the daughter she indicated she had come today for her father's care conference. She said, "He was asleep when I arrived so I went to the conference without him. He's not feeling well." When the resident was asked if he had a special cushion in the recliner he said, "No". This was verified by an LN immediately after the interview with the resident and daughter. On 6/1/06 at 2:30 pm, during an interview with the wound care nurse she stated, "[Resident's name] should have a pressure relieving cushion in the recliner. I thought it was	F 314		

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F 314	Continued From page 14 care planned." On 6/1/06 at 3:00 pm, resident #4's coccyx pressure ulcer was observed. There was a small area of pink and whitish fragile skin where the wound nurse indicated the pressure ulcer had been identified. Resident #4 was admitted to the facility at high risk for recurrence of a newly healed Stage II coccyx ulcer, decreased mobility due to a recent cerebrovascular accident with late effect hemiparesis, and diabetes. The facility failed to appropriately assess, care plan and implement interventions in a timely manner in order to prevent a recurrence of the Stage II coccyx pressure ulcer that developed to a stage III pressure ulcer. The admission wound nurse did not evaluate the resident's skin until the next day after admission. The recurrence of the Stage II coccyx pressure ulcer was documented in the record on 1/2/06. The wound care nurse did not evaluate the wound until 1/5/06 when it had advanced to a Stage III. Further, during survey observations, the resident was not repositioned every 2 hours and did not always have the pressure relieving cushion in place.	F 314		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 324	**F 324 – SS=G - Accidents** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Two residents were noted to be negatively affected by the deficient practice and interventions were put into place to successfully prevent both of these residents from further reoccurrence of falls.	

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F 324	Continued From page 15 Based on record review, review of incident reports, observation and staff interview, it was determined the facility failed to provide adequate supervision and assistive devices to prevent accidents. This was true for 2 of 24 sampled residents (#13 and 18). This resulted in harm for resident #13 when she experienced a fall on 10/23/05 resulting in a hematoma on the occipital bone. The resident experienced 3 falls on 11/2/05 resulting in a right hip fracture following the 3rd fall. Resident #18 was care planned after a fall on 5/22/06 for wheelchair alarms, which were not observed on his wheelchair during the survey. Findings include: 1. Resident #13 was admitted to the facility on 8/17/05 and re-admitted to the facility on 11/14/05 with diagnoses including bronchitis, diabetes mellitis type II, Alzheimer's disease, dementia with behavior disturbance, history of urinary tract infections, osteoporosis, hypothyroidism and hypertension. The admission MDS assessment, dated 8/23/05, indicated the resident had short term memory problems with moderately impaired cognitive skills for daily decision making, no behaviors indicating delirium or periodic disordered thinking/awareness, was able to hear in special situations only with no communication devices/techniques identified, required limited assistance of one with ambulation in her room, had an unsteady gait, ambulation in the hallway had not occurred the previous 7 days and the resident required extensive assistance with toileting. The next MDS assessment was a discharge assessment dated 11/2/05 with return to the facility anticipated.	F 324	F 324 Continued from page 15 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents have the potential to be affected by the deficient practice and therefore corrective actions, as described below, were undertaken. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. To ensure the safety of any resident who has experienced a recent fall and/or is experiencing a change in cognitive status that would adversely impact his/her safety awareness, or is experiencing increased agitation, or is experiencing an infection that may impact their safety/stability - 15-minutes observations will commence. The decision to commence the 15-minute observations (increase the supervision) will be determined by the licensed nurse and/or Unit RN Manager, following an assessment of the resident. A new procedure was implemented related to the need for increased supervision for the above residents. A "Precaution – Observation Form (Initial q 15 minutes – 24 hrs. QD) form will be utilized to document this intervention and provide guidance to the continued monitoring and implementation of incident (fall) prevention interventions. The temporary Care Plan – Falls will be revised to reflect the need for 15-minute checks as an intervention for a recent fall.	

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F 324	Continued From page 16 The resident's "Fall Risk Assessment" dated 8/17/05, documented the resident's total fall risk score as "13". The assessment indicated a total score of 10 or above represented "HIGH RISK". The next documented "Fall Risk Assessment" was dated 4/17/06. The resident's admission "Nursing Progress Note" dated 8/17/05 at 5:10 pm documented, "Resident admitted...c [with] diagnosis of... Chr. [onic] UTI's [urinary tract infections]...Fall risk assessment completed & [and] scored 13 = [equals] high risk for fall. Interventions, room near nurses station, bed & chair alarms, toileting, & nonskid rug @ [at] bedside..." The resident's "Admit Assessment/Nursing" dated 8/17/05, time 11:40 am, indicated short term memory was "problematic", wandering was a behavior, hearing was highly impaired "voice must be raised" and the resident had a history of UTI's. The resident's care plan, dated 8/30/05, documented the problem of "Alteration in Mobility: potential for falls related to osteoarthritis, unsteady gait, dementia with memory deficits, hyptertension [sic], and chronic UTI's..." Approaches included the following: *"Monitor for fatigue, SOB [shortness of breath], etc. Encourage/assist to rest when demonstrates s/sx [signs and symptoms] of fatigue. *Limited to Extensive assist x [of] 1 with transfer, can bear weight, ambulates with FWW [front wheel walker] and extensive assists short	F 324	F 324 Continued from page 16 Pertaining to Resident #18, the temporary care plan that was put into place to prevent re-occurrence of falls was not appropriately marked by the nurse instituting the care plan interventions thus all suggested interventions were deemed to be in effect because none were marked. This care plan is intended to be a guide in determining the most appropriate interventions in the event of a fall – the licensed nurse is to mark or circle the interventions that apply and sign and date the care plan. This nurse failed to do that. To assist in preventing re-occurrence of this potential for deficiencies in care planning and for deficiencies in determining appropriate fall prevention interventions, all temporary care plans were revised to provide □ boxes and a line for the nurses' signature. Licensed nursing staff was inserviced related to the need to completely and accurately determine care plan interventions in the event of a fall and to institute increased supervision (15-minute monitoring) for those residents who are in need of closer supervision following a fall and/or are experiencing a change of condition that might impact their safety. 4. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place.</u> The QA monitor for Incidents and Accidents was updated to audit the incident and accident reports to ensure that, when needed, that 15-minute checks were instituted and that the form was completed as scheduled. The QA monitor for care plans was updated to ensure that temporary care plans are accurate and complete.	

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F 324	Continued From page 17 distances in room, uses W/C [wheelchair] for mobility about facility: can propel self. *1/2 siderails up x [times] 2 for bed mobility. *Supportive devices used: chair and bed alarms. Tag alarms in bed & W/C. *Skilled physical therapy per current plan. *Ensure environment is free from clutter and well lighted. *Ensure proper footwear is in use. *Non skid rug at bedside. *Room is near the nurse's station." The 8/30/06 "Care Plan" documented the intervention of "Room is near the nurse's station" was discontinued 9/20/05. The intervention of "Skilled Physical therapy per current plan" was discontinued 10/6/05. The resident's record revealed no further care plan revisions or updates until 10/23/05. The 8/30/06 "Care Plan" documented the problem of "Alteration in Communication: Resident is HOH and doesn't wear hearing aids. Has difficulty finishing thoughts at times. Hx [history] of dementia." Approaches included, "...Resident calls out for 'nurse' rather than utilizing the call light..." a.) "Nursing Progress Notes" documented the following:	F 324	F 324 Continued from page 17 5. Include dates when corrective action will be completed. Corrective action will be completed by July 7, 2006.	

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	13A035	A. BUILDING _____ B. WING _____	06/02/2006

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F 324	Continued From page 18 *"9/5/05, 2100 [9:00 pm], "...Shortly after going to her room her tag alarm was heard going off. Her W/C was noted to be in front of the elevators but resident was no where in site [sic]...Resident is at high risk of falling because she is standing up constantly from her wheelchair and walking..." *"10/18/05, 7:15 am, Late entry for 10/17/05 1700 [5:00 pm] - Res. continues to have [increased] confusion approx[imately] 1500-2000 as evidenced by her looking for her car...Res. [with] [decreased] anger [with] redirection, but cont. [inues] to have anxiety R/T [related to] memory loss..." *"10/23/05, 1:30 am, Res. found in room on floor by aide. Tag Alarm in res. room and another room sounding and inadequate staffing to attend to her immed[iately]. She was sitting in pool of urine...Hematoma on occipital bone 1 1/2" diameter and raised 1/4"..." The "Resident Incident Report" dated 10/23/05 at 1:00 am documented, "Resident found on floor in doorway to bathroom..." The incident report documented that staff had last contact with the resident at 12:00 am (midnight) and the call light was within reach when he/she fell. Interventions prior to the fall included tag alarm, pressure bed alarm and routine toileting. The "Care Plan" dated 8/30/05 contained a handwritten intervention dated 10/23/05 documenting, "Q 1-2° [checks] @ NOC [nighttime]." b.) "Nursing Progress Notes" documented the following:	F 324		

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F 324	Continued From page 19 *"11/1/05, 3:30 pm, Resident [with] sudden [change] in mood, irritable, loud voice, less directable T[emperature] 98.8° [Fahrenheit] Urine noted as cloudy - 4 fluids refused on AM shift. Slept 3 hr [hours] which is unusual for her. Initial dipstick + [positive] & urine spec[imen] obtained by cath[eter] - 2+ leuk[ocytes] + nitrite 50 blood. Results to physician..." *"11/1/05, 10:30 pm, Abx [antibiotics] started for UTI..." *"11/2/05, 0030 [12:30 am], "Alarms going off, thud heard, resident moaning, went to room, resident on floor at bedside, face down, neuro[ological] [checks] WNL [within normal limits]. ROM [range of motion] WNL. Alert/confused [arrow up indicating increased confusion], blankets wrapped around body, when ask what happened stated "I guess I fell out of bed", returned to bed after using toilet, pressure alarm & tag alarm in use..." The "Resident Incident Report" dated 11/2/05 at 12:30 am documented, "Alarms going off, heard thud & pt.[patient] moaning, went to room, resident on floor at bedside, face down...alert/confused, blankets wrapped around body...Current Interventions in place: Tag & pressure alarm, non skid mat at bedside. Immediate interventions implemented: [Check] on resident frequently, foam mat on floor next to bed..." The incident report documented that staff had toileted the resident at 11:00 pm on 11/1/05 and the call light was within reach when he/she fell.	F 324		

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F 324	Continued From page 20 The resident's record provided no documented evidence that prior to the fall on 11/2/05 at 12:30 am, the resident received checks every 1-2 hours at night as care planned on 10/23/05 or that supervision was increased following the resident's sudden change in mood and subsequent diagnosis of a urinary tract infection. c.) On 11/2/05, 0348 [3:48 am], "Nursing Progress Notes" documented, ...Alarms going off, found resident [with] body in sitting position [with] L[eft] arm pinned behind side rail...returned to bed, alarms on, mat placed at bedside, neuro [checks] WNL..." The "Resident Incident Report" dated 11/2/05 at 3:48 am documented, "Alarms going off found resident [with] body in sitting position [with] L[eft] arm pinned behind side rail...Current Interventions in Place: Pressure & tag alarms in use, non skid mat at bedside...foam mat on floor next to bed. Immediate Interventions Implemented: ...Added full SR [siderail] on door side of the bed. The incident report documented the last time the resident was toileted as 2:00 am and the last staff contact with resident as 3:00 am. The resident's "Neurological Assessment Flowsheet" dated 11/2/05 documented the resident received neurological checks every 15 minutes from 12:30 am through 1:15 am, and 30 minute checks from 1:15 am through 3:15 am. The "Care Plan" dated 8/30/05 contained a handwritten intervention dated 11/2/05 documenting, "1 1/2 siderails [up] to enable bed mobility & to ensure safe repositioning @ NOC to	F 324		

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F 324	Continued From page 21 [decrease risk of falling OOB [out of bed]." d.) 11/2/05 2300 [11:00 pm], "Nursing Progress Notes" documented, "CNA went to check sounding alarm et [and] found resident on floor in BR [bathroom] @ 2210 [10:10 pm]. This nurse entered to find res. lying on R[ight] side [with] R. arm curled under her. Repositioned to supine position. Floor covered in urine...R. leg unable to be extended [without] extreme pain...Transported to ER [emergency room] @ 2250 [10:50 pm]." The "Resident Incident Report" dated 11/2/05 at 10:10 pm documented, "I heard alarm while with other Res. and I heard [Resident's name] fall and yell for help. I found her lying on bathroom floor on right side. She said she slipped & fell...Current Interventions in Place: Pressure alarm in place & sounding. Tag alarm in place, but [not] on resident. Mat on floor next to bed. Bed alarm on et. [and] was sounding. Immediate Interventions Implemented: Res. kept in supine position. Did not force R. leg to straighten. Sent to ER for evaluation (X-ray)." The incident report documented the last time the resident was toileted as 8:00 pm, and the last staff contact with resident as 9:15 pm. A physician's order dated 11/2/05, time 10:25 pm, documented, "1. Transport to [hospital's name] for evaluation..." The "Physician Discharge Summary" dated 11/2/05 and signed by the physician on 11/15/05 documented, "Provisional Diagnosis: Dementia [with] unstable mood, hypothyroidism, GERD [gastroesophageal reflux disease], depression, osteoarthritis, [unreadable]...Final Diagnosis:	F 324		

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F 324	Continued From page 22 Above plus right hip fracture...Course of Treatment: Admitted for ongoing care. Stable except for difficulty managing impulsiveness and unstable mood during stay. Despite bed alarm pt. self transferred out of bed. Fell, injured right hip. Condition on Discharge: Acute injury R. hip..." The resident's "Neurological Assessment Flowsheet" dated 11/2/05 documented the resident received neurological checks at 4:15 am, 5:15 am, 7:15 am, 9:15 am, 1:00 pm and 5:00 pm. "Nursing Progress Notes" dated 11/2/05, time 9:45 pm documented, "T[emperature] 97.4...[No] additional injuries noted from previous fall..." The resident's record provided no documented evidence the resident consistently received frequent checks or increased supervision following the her 2nd fall on 11/2/05 at 3:48 am. Unit care coordinator interview and observations of the resident during the survey, revealed the resident resided in a room at the far end of the hallway which was the furthest room from the nurses' station. Record review revealed the resident remained in this room prior to the 10/23/05 fall and throughout the 4 falls from 10/23/05 through 11/2/05. On 6/1/06 at 1:35 pm, the DON and unit care coordinator were interviewed regarding the fall prevention interventions which were in place prior to each of the resident's falls, and changes in care plan interventions following each fall. The unit care coordinator stated that upon admission 8/17/05, the resident was belligerent, had no	F 324		

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F 324	Continued From page 23 safety awareness and her sundowner's was extremely bad. She stated the resident was extremely mobile, dissembled alarms, had an unsteady gait and a history of UTI's. She stated the resident was referred for a psychiatric consultation but that a low bed would have been devastating to the resident at that time. The unit care coordinator stated the resident was moved to her present room approximately 2 weeks after admission and she was unable to move the resident closer to the nurses' station for increased supervision at the time of the falls due to availability of rooms. The unit care coordinator stated updated interventions were written all over the care plan as they were added. Resident #13 was admitted to the facility at risk for falls. The facility failed to identify and implement effective preventative measures which resulted in harm when resident #13 had 4 falls from 10/23/05 through 11/2/05, including the last fall which resulted in a right hip fracture. The facility failed to thoroughly assess and implement preventative measures, including consistently increasing supervision after identifying the resident's high risk for falls, hearing deficit, unwillingness to use a call light button, cognitive/decision making deficit and change in mood and behaviors following the diagnosis of a UTI. 2. Resident #18 was admitted to the facility on 10/02/02, with the diagnoses of dementia, diabetes mellitus, obesity and osteoarthroses. The medicare quarterly review assessment MDS,	F 324		

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F 324	Continued From page 24	F 324		

signed 5/22/06, under accidents, indicated the resident fell in the past 30 days, and also fell in the past 31-180 days.

The care plan, dated 5/22/06, identified a problem: "Decreased mobility; potential for falls." Approaches included, "Utilize alarms while in w/c [wheelchair]."

The nurses notes on 05/22/06 at 5:55 pm document that on 05/22/06, resident #18 fell while self transferring from his wheelchair to a recliner. The Fall Risk Assessment scored resident #18 at a score of 17. A total score of 10 or above represents high risk for falls.

On 6/01/06 resident #18 was observed at 9:00 am sitting in his room in his wheelchair with no wheelchair alarms in place. When asked, the resident confirmed that there were no wheelchair alarms on his wheelchair.

On 6/1/06 at 9:45 am, a staff interview was conducted with the Unit Manager regarding resident #18's wheelchair alarms. The surveyor reviewed the fact that the care plan instructed staff that resident #18 was to have wheelchair alarms in place while he is in the wheelchair. The Unit Manager confirmed that resident #18 does not have wheelchair alarms on his wheelchair. She stated that after the resident's fall on 05/22/06 the care plan had been mistakenly updated to include wheelchair alarms. The only update that should have been made was for resident #18 to have one person assist with transfers.

The facility failed to follow the care plan regarding

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F 324	Continued From page 25 resident #18's fall risk by placing wheelchair alarms on his wheelchair.	F 324		

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The following deficiencies were cited during the annual State licensure survey of your facility. The surveyors conducting the survey were: Winnie Young, RN, Team Coordinator Kim Heuman, RN Diane Miller, LCSW Lory Dayley, RD Karen McDannel, RN Lea Stoltz, QMRP Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	C 000	RECEIVED JUN 26 2006 FACILITY STANDARDS	
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it related to periodically reviewing and revising care plan assessments.	C 782	Please refer to Plan of Correction F 280	
C 784	02.200,03,b	C 784		

Bureau of Facility Standards

James R. Roberts NHA
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: ADMINISTRATOR

(X6) DATE: 6/26/2006

Bureau of Facility Standards

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C 784	Continued From page 1 b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F246 and F309 as it related to residents receiving the necessary care and services to attain or maintain the highest practicable functioning level and accessibility of call lights.	C 784	Please refer to Plan of Correction F246 and F309	
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to the F314 as it addresses prevention and treatment of Pressure Sores.	C 789	Please refer to Plan of Correction F314	
C 790	02.200,03,b,vi vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F324 as it relates to prevention of falls and accidents.	C 790	Please refer to Plan of Correction F324	